Girl Health History and Emergency Medical Authorization Form

This form must be completed annually and as changes occur by the child's parent or guardian and returned to the troop leader and/or troop first-aider prior to attending the first troop meeting. Use additional paper if needed.

Child's Name: ______________________ Date of Birth (dd/mm/yyyy) ______________ Age: _______

Street Address: ______________________ City: ______________ Post Code: ______________

School: ______________________ Grade: __________ Troop Number: ______________

PARENT/GUARDIAN INFORMATION

Child is in the custodial care of: ☐ Both Parents ☐ Mother Only ☐ Father Only ☐ Other: ______________

Parent/Guardian 1: ______________________ Relationship: ______________

Address (if different from child's): Street: ______________ City: __________ Post Code: __________

Phone 1: ______________ Phone 2: ______________ Email: ______________

Parent/Guardian 2: ______________________ Relationship: ______________

Address (if different from child's): Street: ______________ City: __________ Post Code: __________

Phone 1: ______________ Phone 2: ______________ Email: ______________

EMERGENCY CONTACTS (other than parents/guardians)

Emergency Contact 1: Name: ______________________ Relationship: ______________

Phone 1: ______________________ Phone 2: ______________________

Emergency Contact 2: Name: ______________________ Relationship: ______________

Phone 1: ______________________ Phone 2: ______________________

HEALTH INFORMATION

Allergies? ☐ **Yes** ☐ **No**

If "yes," please explain in detail the type of allergy (animals, insect stings, plants/trees, food, drugs, or other), severity of reaction, and any medication, if needed.

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Check all that apply and provide requested information. Attach a separate page if necessary.

Condition	Explain any "yes" answers	Condition	Explain any "yes" answers
☐ ADD/ADHD		☐ Hearing	
☐ Arthritis		☐ Heart Defect/Disease	
☐ Asthma		☐ Hypertension	
☐ Bleeding/Clotting Disorder		☐ Kidney Disease	
☐ Bronchitis		☐ Motion Sickness	
☐ Constipation		☐ Muscle Disease/Disorder	
☐ Convulsions		☐ Nervous System Disorder	
☐ Diabetes		☐ Sickle Cell Anemia	
☐ Ear Infections		☐ Sinusitis	
☐ Epilepsy		☐ Skeletal Disease/Disorder	
☐ Fainting		☐ Skin Conditions	
☐ Hay Fever		☐ Urinary Tract Infections	
☐ Headaches/Migranes		Wears ☐ Contacts ☐ Glasses	

Please turn over to fill out the back of the form ➜

Explain any specific needs or accommodations required: ____

Explain any known behavioral and/or emotional problems: ____

Explain any adverse reactions to anesthesia: ____

Explain any operations or serious injuries: ____

Explain any disabilities or chronic or recurring illnesses: ____

Explain any dietary modifications: ____

Has menstruation begun? ☐ Yes ☐ No If not, does she know what it is? ☐ Yes ☐ No

IMMUNIZATION HISTORY

Are all immunizations current? ☐ Yes ☐ No If you have them, please attach a copy of your daughter's immunization records.

MEDICATION INFORMATION

Are any prescription medications being taken? ☐ Yes ☐ No

Are any of the following used? ☐ Inhaler ☐ EpiPen

Name of Medication	Reason for Medication	Dosage	Frequency

My child may be given: ☐Ibuprofen ☐Paracetamol ☐Antihistamine ☐None

MEDICAL CARE AND INSURANCE INFORMATION

Child's NHS #______________ Physician: ____________________________ Phone: ________________________

Dentist/Orthodontist: ____ Phone: __________________________

Do you have private health insurance? ☐ Yes ☐ No (If "yes," please complete the following:)

Insurance Company: ________________________ Policy #: __________________ Group #: ______________________

Policy Holder: ______________________ Insurance Company Phone: ______________________________________

Insurance Company Address: ____

AUTHORIZATION FOR MEDICAL CARE

This health history is correct so far as I know. The person herein described has permission to engage in all activities except as noted. I hereby give permission to the First-Aider or Adult-In-Charge to provide routine health care and witness prescribed medications. I consent for my child to receive such medical treatment and/or surgical procedures as are deemed necessary in the event of an emergency and to assume liability for any medical expenses involved. This authorization extends to my child's participation in any activity sponsored by Girl Scouts of the USA, Girl Scouts Overseas Runnymede, or individual units. Should a medical emergency arise during my child's participation in a Girl Scout-sponsored activity, I understand that reasonable efforts will be made to contact me or my designated alternate at the phone numbers I have given. If it is believed my child's life or health may be adversely affected by the delay that an attempt to contact me or my designated alternate would cause, I consent to the administration of medical treatment and/or surgical procedure deemed necessary by the medical doctor and/or medical facility and the immediate administration of life-sustaining measures deemed necessary under the circumstances. This completed form may be photocopied.

Signature: ____ Date: _________________________